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Veröffentlichungsversion / Published Version
Zeitschriftenartikel / journal article

Empfohlene Zitierung / Suggested Citation:
Silva, L. A. d., Alves, V. H., Rodrigues, D. P., Padoin, S. M. d. M., Branco, M. B. L. R., & Souza, R. d. M. P. d. (2015). The quality of an integrated network: accessibility and coverage in prenatal care. *Revista de Pesquisa: Cuidado é Fundamental Online*, *7*(2), 2298-2309. https://doi.org/10.9789/2175-5361.2015.v7i2.2298-2309

Federal University of Rio de Janeiro State
Journal of Research Fundamental Care Online
ISSN 2175-5361
DOI: 10.9789/2175-5361

RESEARCH

A qualidade de uma rede integrada: acessibilidade e cobertura no pré-natal

The quality of an integrated network: accessibility and coverage in prenatal care

La calidad de una red integrada: accesibilidad y cobertura en prenatal

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ABSTRACT

Objective: analyzing the values expressed in the speech of women/mothers in the accessibility of monitoring examinations of prenatal care. **Method:** a phenomenological, descriptive, exploratory study with a qualitative approach. There were interviwed fifty women/pregnant of the Prenatal Program of Niteroi, Rio de Janeiro, Brazil. The data analyzed allowed formulating themes articulated with the Theory of Values. **Results:** barriers experienced by women on laboratory/images examinations: delay in results, misinformation and lack of a service of quality, a value considered of vital use for them. We realize the need for change in monitoring prenatal, considering a network of unified and integrated health with quality services at different levels of care, promoting wellness, comfort and safety to pregnant women as a vital value to their health. **Conclusion:** the health network should be unified for a better quality of services offered to women. **Descriptors:** Women's health, Social values, Prenatal care, Health services accessibility.

RESUMO

Objetivo: analisar os valores expressos no discurso das mulheres/gestantes sob a acessibilidade dos exames no acompanhamento pré-natal. **Método:** estudo fenomenológico, descritivo, exploratório com abordagem qualitativa. Foram entrevistadas cinquenta mulheres/gestantes do Programa de pré-natal do município de Niterói, Rio de Janeiro, Brasil. Os dados analisados permitiram formular categorias temáticas articuladas com a Teoria dos Valores. **Resultados:** os obstáculos vivenciados pelas mulheres na realização dos exames laboratoriais/imagens foram: demora nos resultados, desinformação e escassez de um serviço de qualidade, considerado um valor de utilidade vital para elas. Percebemos a necessidade de mudança no acompanhamento do pré-natal, considerando uma rede de saúde unificada e integrada com serviços de qualidade nos seus diversos níveis de atenção à saúde, promovendo o bem estar, o conforto e a segurança à mulher gestante como valor vital à saúde da mesma. **Conclusão:** a rede de saúde deve-se estar unificada para uma melhor qualidade aos serviços oferecidos à mulher. **Descritores:** Saúde da mulher, Valores sociais, Cuidado pré-natal, Acesso aos serviços de saúde.

RESUMEN

Objetivo: analizar los valores expresados en el discurso de las mujeres/madres en la accesibilidad a los exámenes de monitoreo de la atención prenatal. **Método:** es un estudio fenomenológico, descriptivo y exploratorio con enfoque cualitativo. Se entrevistó cincuenta mujeres/mujeres embarazadas del Programa Prenatal de Niteroi, Río de Janeiro, Brasil. Los datos fueron analizados permiten formular temas articulados con la Teoría de los Valores. **Resultados**: los obstáculos experimentados por las mujeres en la realización de exámenes de laboratorio /images fueron: retraso en los resultados, la desinformación y la falta de un servicio de calidad, un valor considerado de uso vital para ellos. Nos damos cuenta de la necesidad de un cambio en el control prenatal considerando una red de salud unificada e integrada con servicios de calidad en los diferentes niveles de atención de la salud, promovendo el bienestar, la comodidad y la seguridad de las mujeres embarazadas como un valor vital para su salud. **Conclusión:** la red de salud debe ser unificada a una mejor calidad de los servicios ofrecidos a la mujer.**Descriptores:** Salud de la mujer, Valores sociales, Atención prenatal, Accesibilidad a los servicios de salud.

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INTRODUCTION

The quality of prenatal monitoring is the focus of the present study and incorporates part of the search results: "Prenatal the municipal health network of Niteroi: the assistance expressed in the voice of pregnant women". It is subject of interest due to the increasing demand from social movements, the World Health Organization (WHO) and organized sectors of society, culminating in public policies that favor the quality of prenatal care. Thus, the present study points out to women's/ pregnant women values, as the accessibility of tests in monitoring prenatal.

Thus, prenatal care comprises a set of care and procedures aimed at preserving the health of the mother and the fetus, ensuring the prevention and early detection of own pregnancy complications and appropriate treatment of pre-existing maternal events. In addition, prenatal may represent a unique opportunity for women receiving health care.[1]

The quality of care in health service is one of the current scopes of the Ministry of Health (MOH), especially in the area of women's health. The challenges of quality of care in monitoring prenatal, birth and postpartum, can be seen by the high maternal mortality rate, creating obstacles to Brazil reach its goal in relation to the 5th goal of the United Nations Millennium Development (UN) for quality of maternal health improvement.[2]

Prenatal care quality stands out as the first target to be hit when it seeks to reducing maternal and perinatal mortality rates.[3] Thus, the accessibility to health service laboratory tests is essential for the health panel change of the woman; who, through the Program for Humanization of Prenatal and Birth (PHPN) and the National Policy for Integral Attention to Women's Health (PNAISM) contributes to the achievement of this objective. These policies are intended to expand access to health services, coverage and quality of care in the perinatal period. It should be noted, though, the emphasis of these policies, focusing on comprehensive health care for women, seeking to make them accessible to a care of quality.[4]

This accessibility is related to the concept of completeness; this principle is that the guidelines governing the Unified Health System (SUS), which sets up an integrated system at all levels of complexity. Already, integration can be seen as a network of services with access conditions and solves the population problems. This coordination includes all health services, including prenatal care.[5]

Regarding the coverage of laboratory tests, the MoH establishes accessibility tests, such as ABO-Rh, hemoglobin/hematocrit VDRL, urinalysis; fasting glucose; HIV testing; serology for hepatitis B (HBsAg), serology for toxoplasmosis, Pap smear.[6,7] Still, the strategy of Stork Network, established in 2011, to promoting quality of care for women through expansion and accessibility to examinations before prenatal.

Thus, the study identified the concerns of women in prenatal, allowing understand their real needs during follow-up and the obstacles encountered, allowing the valuation of women's imagination about the quality of the health service to promoting a change in reality of the health system and transforming the offered care.

In Brazil, the Integral Attention to Women's Health Policy (PAISM) recommends, among other actions, a quality monitoring for the promotion of health and maternal and fetal wellness.[2] So, it needs to understand the process of prenatal care, in particular to the accessibility component of the examinations offered during pregnancy; thus, ensuring the quality of care offered to pregnant women.

Given the above, there were determined the following objectives: analyzing the values expressed in the women's discourse/pregnant women in the accessibility of exams of prenatal care.

METHOD

This is a phenomenological study, descriptive, exploratory of a qualitative approach, determining the valuation of subjective data as a strategy of social research .[8]

The research was conducted after approval by the Research Ethics Committee of the Faculty of Medicine of the University Hospital Antônio Pedro (HUAP), linked to the Fluminense Federal University (UFF), under CAEE Protocol: 06604012.0.0000.5243 as provided Resolution No. 466/12 of National Health Council (CNS). To begin the study, we asked the responsible for the Basic Care Units, study settings, to give access to those environments, obtaining proper authorization.

The study participants were composed of fifty women/pregnant women followed in the Prenatal Program in Primary Care in the city of Niteroi, Rio de Janeiro, Brazil, with the inclusion criteria: being women/pregnant of eighteen years old or older, enrolled in the program pre-natal of the city, and prenatal usual risk. The exclusion criteria took into account pregnant women followed at high risk prenatal care.

They all signed the Informed Consent (IC) conditioned on their voluntary participation in the study, ensuring their anonymity and the confidentiality of information by using an alphanumeric code (G1 ... G50). There was used as a technique the individual semi-structured interview, designed with open and closed questions, which portrayed the socio-economic and welfare aspects, beyond the perception of availability of tests for the monitoring of prenatal care. Data collection took place through the researchers during the period January to June 2013, the Primary Care Units. The interviews were recorded on a digital device with prior approval of pregnant women, later reports were transcribed and

validated by researchers of the reliability of what they had said and then subjected to analysis.

To analyzing the collected data it was chosen for the statistical analysis only to determining the characterization of the profile of the participants. And the content analysis on thematic issues, relevant to the values of the participants, which did emerge a thematic category [8], being that in the final stage of this analysis, was to establishing links between the data collected and the Theory of Max Scheler values, philosophy the values that enabled discussing and establishing the view of pregnant women to achieving the objectives proposed in the study.[9] As a result, to the extent that followed the reports of women/mothers, there was established the following Schelerian meaning: *Accessibility a required value: echoes of Public Health Policies in Prenatal*.

RESULTS AND DISCUSSION

In this study, the population in the age group of 18 to 25 years old, twenty-four women (48%), followed by fourteen aged 30-35 (28%). These results are in line with the Brazilian Institute of Geography and Statistics, which decided in its last Census the total population of 86.223.155 women, of which 46.911.428 were in reproductive age, ie between 10-39 years old.[2]

The participants were mostly of mixed ethnicity, twenty-five women (50%), followed by thirteen black (26%). The predominant religion was Protestant, with twenty-one women (42%), followed by seventeen Catholics (34%). The dominant marital status was the single, forty women (80%), followed married for ten (20%), whose family income does not exceed two current minimum wages in the current R$ 678,00 evidenced by nineteen women (38%), similar to the results of another study of the ethnicity, marital status and income familiar.[3] This population had no employment relationship, depending on family, twenty-nine women unemployed (58%). However, twenty-one had an occupation with a formal contract (42%) and contribute to family income.

The predominant level of education was not completed secondary school, with thirty-one women (62%), though there is a population with low level of education, followed by sixteen with complete basic education (32%). This finding was similar to that found in one study.[10] However, distinct from the other 11, it showed women with high school education.

By investigating the pregnancy data, there was predominance of twenty-six multiparous women (52%). The current pregnancy was identified as unplanned by thirty-five patients (70%). The first factor evidenced in another study[11]a given similar; however,

unwanted pregnancy is a different element in the same study that observed multiparous women with unplanned pregnancy.

Family support is essential to maternal and fetal health, and was found by forty-eight women (96%). This support means during the consultations, as twenty-nine of pregnant women were accompanied by family members or their partners (58%), similar to data from a study that showed 38% of women followed during prenatal consultations.[12] This fact is essential for the safety of pregnancy and family interaction in the process of gestating and giving birth, a fact presented by thirty-six women (72%).

Work is a factor that hinders the participation of parents in prenatal consultations, for the times of the same place in the commercial period, making it unfavorable to their inclusion. Working relationships hinder participation in antenatal clinics because they do not accept that man miss work to assisting his wife and child.[12] This fact should be further discussed for the promotion of paternity during the gestational process.

Regarding the quality of the consultations offered by the health system, we found that forty-one women (82%) started monitoring the prenatal during the first trimester of pregnancy, as relevant as it follows the recommendations of the Ministry of Health.[6] During consultations made, forty-eight patients (96%) had good service by the health professional and appropriate answers to their questions about pregnancy and birth, with a percentage of forty-seven women (94%). Yet, thirty-one women (62%) reported that they were served their emotional demands in prenatal care. However, the technicality of prenatal care shows that there is still lack of involvement of health professionals in the consultations and practices geared to the needs of pregnant women, attitude prevailing over the specific care that the pregnant woman requires.

In addition, the study pointed out the difficulties/obstacles before the completion of laboratory tests/image with a percentage of thirty-two women (72%). The reasons noted dissatisfaction of the prenatal care service were delays in care, appointed for twenty-five women (50%), followed by inadequate facilities cited for twenty-one (42%), and terrible service, referred to by four (8%) women, adverse situations that directly impact the health of the woman and her fetus.

Accessibility a necessary value: echoes of Public Health Policies in the Prenatal

The implementation of welfare policy in prenatal care is important for greater interaction of the city with the population's health. Thus, the slow process of realization and receipt of test results, shows a failure in the care of the health system; Furthermore, the network obstacles to accessing imaging studies, such as ultrasound, with schedules restriction for the meeting, committed to service quality of maternal and fetal health, as follows testimonials:

> *The first I made private, because I was afraid of taking longer (...) then the doctor complained that I spent money for nothing and the other I did here, but haven't received it yet.* (G1)

> *To getting, it took too long! (...) more than a month.* (G2)

> *Why did my examination of urine that was even not ready, the urinalculture (...) I hope it arrives soon, because I'm afraid the result takes longer.* (G3)

The respondents reported concern about the waiting time of examination results; dissatisfaction with the predetermined times that restrict accessibility to health care services and creates obstacles; the lack of information that generates fear, anguish and uncertainty as to the issue of monitoring, constituting obstacle in women's health in their reproductive issues, either because the operating system institutionalization, is directly linked to their health, safety, according to their statements:

> *Should have more days of collecting blood, urine and feces, because I work a lot, and I can't do in some timetables.* (G5)

> *Because the blood I couldn't really make, always hasn't been the result, said wasn't ready, that the blood was not enough.* (G6)

> *I made the first private tests, and another I made here it took, there was told it had to be early (...) had already 12 hours of fasting, and I couldn't do it. I had to come back another day, by lack of information.* (G7)

Another difficulty was pointed conducting imaging tests, as testimony of pregnant women:

> The ultra that made particular the doctor said that if he was here I wouldn't receive so early. (G4)

> *Most did in the same health center, only the ultra I did because I couldn't by SUS.* (G8)

> The exams were easy to make and pick up later. Only the ultra that I particularly, I think the health center has not. (G9)

Initially, it is important to emphasizing that the Law 8080 of 1990 governing the Health System ensures universal and equal access of the population to programs and services for the promotion, protection and recovery of health, and the award of the State to ensure these conditions.[2] It is clear; however, that this principle is infringed by being remarkable the unavailability of human and material resources in health services, which hamper the prenatal care, which end up not happening in a quiet, fast and effective way, with condition monitoring effective health of pregnant women.

It is known that occur in everyday life certain purchases of values that do not represent the scientific knowledge.[13] When a scientific thought - the theory is encompassed by everyday thinking - the evaluative practice, everyday knowledge encompasses in its own structure. Thus, the individual values of acquisitions are presented in isolated everyday knowledge and involved in the pragmatism of daily life, and become your guide, resulting in relation to the accessibility of pregnant women to prenatal care, the values established in the individual field women are added to the collective values that engender the know-how everyday prenatal health service that works with the pregnant women.

Accessing health services is of paramount importance so that care is established safely; therefore, there should be no obstacles that discredit the system, because the accessibility to health services is considered an essential point of a health system, occurs when the process of seeking and obtaining care.[14]

Although accessibility is a concept related to coverage, they are not equivalent. The coverage is related to the intensity of the supply of actions and services, or to the extent that existing resources are sufficient to meet the target population's needs. On the other hand, accessibility has been defined as a relationship between the power resources of the users and the obstacles placed by the health services. The power resources relate to issues of economic, social and cultural nature. Have the obstacles may be geographical (distance, transport), organizational (length of lines, unjustifiable waiting time, nature of the host) and economic.[15]

In this sense, where there are major difficulties for the use of the health service, the concept of accessibility related to barriers to the achievement of services by users, is plus great value, as is the case in Brazil. Thus, we point out that obstacles related to the accessibility of health services are provided with a utility value, which is a value for a vital essence, or "useful" is all looking so "ruled" the achievement of a value good, pleasing to the senses. Nice is a fundamental value; the useful, the value thereof. In this sense, the value of modern society is guided by utility, consisting for the enjoyment of pleasurable things.[9] Thus, accessibility is a vital value inherent in the utility value of the health service; therefore, the health system barriers to delivering the impracticability of vital values and utility.

The obstacles experienced by women/mothers regarding basic care network women's health, which is a strong point about the accessibility prenatal, running through the laboratory tests and imaging, becoming vital value and utility,[9] as well as essential for maternal and fetal health.

The Humanization Program of Prenatal and Birth (PHPN) has as one of its objectives to ensuring better access, coverage and quality of prenatal care.[6] This proposal is essential in the context of sexual and reproductive rights, as well to contributing to the diagnosis and treatment of possible complications during pregnancy in order to promote mainly the decline in maternal mortality, collaborating with the 5th goal of the UN Millennium Development Goals, about improving the health of pregnant women in Brazil.

Thus, this contribution is assigned to the examinations in the prenatal that may reveal the health of the pregnant woman and her child, for the quality of information, and the

availability of services in prenatal care, leave them more safe, secure and peaceful, in relation to maternal and fetal health.[16]

However, the network of integrated health care should have a unified structure, allowing the mother to having quick access to laboratory tests, inhibiting the obstacles of the system health.[17] Thus, it is important to highlighting a current study that demonstrated a high rate of diagnosis of maternal morbidity among women interned in a maternity in Teresina (PI), explained by ineffective management of laboratory basic tests.[1] However, a study in the city of Rio de Janeiro shows that the main difficulties for the management of syphilis and HIV during pregnancy, were related to the late start of prenatal care, plus the delay of examination results, which took more than thirty days to get available.[18]

In this perspective, the vital values are universal: we all need food, health and safety, understood as basic for survival and are useful for the maintenance of life. With regard to health and maternal and fetal well-being, the effective management of prenatal monitoring is done as a basic health need. It constitutes a matter of vital value with respect to monitoring the health during pregnancy, with the implementation of the clinical and laboratory tests recommended in the Ministry of Health, recognized for its benefits for the screening of the possible clinical changes.[9]

For an integrated network in women's health, in the context of pregnancy and childbirth, is essential that the pregnant woman has the possibility of a diagnostic quality of her health. This will only be done when the results are made available in a timely manner. However, this accessibility is not found, constituting disregard the health rights of women as a vital value.

The duties of municipal managers include ensuring and providing the operationalization of health care supported by Ordinances and Ministry of Health protocols. These characteristics contribute to the real picture of maternal mortality in Brazil, favoring the precariousness of obstetric care, and contributing to the country become more distant with respect to governmental targets for changing of health scene.

The service evaluation system must be effective in order to reordering the execution of actions and services, resizing them to take account of the needs of their audience, offering greater rationality in the operation of health resources and the population's access, such as information relevant, which are not provided with clarity in understanding the pregnants.[19] This fact establishes a breach of basics in relation to public health, as the institutionalization made with standards and operating rules that underlie the lack of knowledge about health the pregnant woman, directly interferes with your health, making a vital value for your comfort, safety and welfare.

The vital value finds itself deeply rooted in what is most intimate of human beings; is immanent to it, is at the core of their existence and has, therefore, the highest significance for the understanding of accessibility process to prenatal care as a right of women / mothers and their newborns.

Thus, the principles of the SUS equity and resolution should ensure the patient the right to a service that meets their basic needs, without leaving it exposed to constraints, mainly because of misinformation and lack of time for the realization of prenatal tests. It should be remembered that, according to the recommended by the Ministry of Health, it

must respect the individuality of women, increasing their ability to making choices based on the knowledge of their rights established by inhibiting obstacles for their experienced.[6]

The provider of primary care investigated the municipality must seek to understand the health picture of the population it serves. Similarly, health managers should be engaged and committed to the quality of care offered and subsidizes it for the effectiveness of its operation, with a focus on quality and satisfaction of reproductive health of the pregnant woman.

Gestational age is calculated from the last menstrual period, which is reliable. Thus, it is important to ensuring the pregnant woman conducting ultrasonography that in addition to reaffirming the gestational age, helps in early detection of twin pregnancies, type of placentation and cases of fetal malformations clinically not apparent.[6]Therefore, and because it an assistive technology for the production of health, the imaging test is vital value to the quality of monitoring of pregnancy.

It is important noting that not using ultrasound during pregnancy does not constitute omission or diminish the quality of prenatal.[6]However, from the moment that the health professional asks imaging, the network must be able to provide the service to its implementation, without creating obstacles or difficulties as those faced by municipal pregnant.

These difficulties constitute an important point to be mentioned to ensuring adequate management of the prenatal care, because it allows targeting of program activities in healthcare and central, with protocols for a redefinition of the physical and human resources in the secondary level of service. However, it is emphasized that the fact that pregnant women not to perform ultrasound, for example, does not prove scientifically that may occur elevation of maternal and fetal morbidity and mortality, but proves that the health system of the municipality violates recommended by the SUS for failing to ensure the right of access to users to perform imaging studies requested by health professionals.

Relate right of users accessibility to tests for prenatal and citizenship, is a discourse that shows committed to the real social problems experienced by pregnant women, understanding that the valuation of the latter is a matter of conquest, not giving, and the prenatal consultation, in its broadest sense, is interrelated with this achievement evaluative.[20]

Thus, the Stork Network reaffirms that the achievement of prenatal tests of low and high risk, and access to their results, must be timely; it is proposed that from its accession, new tests funded by the Ministry of Health to expand the performance of obstetric ultrasound to 100% of pregnant women and obstetric ultrasound with Doppler. Thus, these data indicate for the health managers of the municipality, the need for accreditation to Stork Network Program. This is a possible solution to the magnification and resolution of problems related to health accessibility.

CONCLUSION

The reflections about the subject in focus approach the Max Scheller theory, thus allowing to reveal the thought of women/pregnant women in prenatal monitoring with regard to assessing the quality offered by the current health system, never fully satisfied, since this way of valuing mean they have ensured their desires, and for that, they need to be revealed. It is clear that to their satisfaction emerging personal values as marks in the care process guided in the aspects of utility, passing a vital value closely connected with the quality monitoring.

It was observed that the speeches are steeped in shortages related to a skilled care during prenatal care, compared with accessibility barriers and coverage of laboratory tests/images, generating anxiety and fear. This fact is connected with the quality of care offered and received, considered a vital value for maternal and fetal health, one imbricated value oriented issues to the usefulness of care, ie, a vital value for their well-being, from this care quality.

Thus, we see the potential need for change in the prenatal panel, with a network of unified and integrated health, and quality services. It is considered as paramount, to establishing the target for the humanization of care to the population, and adopting specific strategies for popular participation, in addition to municipal management providing the necessary conditions, such as physical space and equipment, thus salvaging the right of women a warm and unquestionable quality monitoring.

REFERENCES

1. Fonsêca LAC, Pádua LB, Neto JDV. Avaliação da qualidade da assistência pré-natal prestada às gestantes usuárias do sistema único de saúde. Rev. Interd. Novafari. 2011; 4(2): 40-45.

2. Ministério da Saúde (Br). Política nacional de atenção integral à saúde da mulher: princípios e diretrizes. Brasília: Ministério da Saúde; 2011. [citado 2013 Dezembro 12]. Disponível em: URL: http://bvsms.saude.gov.br/bvs/publicacoes/politica_nacional_mulher_principios_diretrizes.pdf

3. Costa JSD, Cesar JA, Haag CB, Watter G, Vicenzi K, Schaefer R. Inadequação do pré-natal em áreas pobres no Nordeste do Brasil: prevalência e alguns fatores associados. Rev Bras. Saúde Matern. Infant. 2013; 13(2): 101-109.

4. Basso CG, Neves ET, Silveira A. The association between attending prenatal care and neonatal morbidity. Texto Contexto Enferm. 2012; 21(2): 269-275.

5. Reis CB, Andrade SMO. Representações sociais das enfermeiras sobre a integralidade na assistência à saúde da mulher na rede básica. Ciênc. Saúde Coletiva. 2008; 13(1): 61-70.

6. Ministério da Saúde. Atenção ao pré-natal de baixo risco. Brasília: Ministério da Saúde; 2012.

7. Assad FM, Rech CRA. Avaliação da atenção pré-natal na unidade básica de saúde de São Bernardino - SC. Rev. Saúde Públ. Santa Cat. 2010; 3(2): 20-33.

8. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 12ª ed. São Paulo (SP): HUCITEC; 2010.

9. Scheler M. Da reviravolta dos valores. 2ª ed. Petrópolis (RJ): Vozes; 2012.

10. Spindola T, Penna LHG, Progianti JM. Perfil epidemiológico de mulheres atendidas na consulta de pré-natal de um hospital universitário. Rev. Esc. Enferm. USP. 2006; 40(3): 381-388.

11. Lima AF, Melo AMAA, Ferreira MA. Pré-natal: um desafia para gestantes acompanhadas nas unidades de saúde da família no município de Serra Talhada - PE. Saúde Coletiva em Debate. 2012; 2(1): 31-40.

12. Oliveira SC, Ferreira JG, Silva PMP, Ferreira JM, Seabra RA, Fernando VCN. A participação do homem/pai no acompanhamento da assistência pré-natal. Cogitare Enferm. 2009; 14(1): 73-8.

13. Pereira RMB. O sistema ético-filosófico dos valores de Max Scheler. Porto Alegre (RS): EST; 2000.

14. Cunha ABO, Silva LMV. Acessibilidade aos serviços de saúde em um município do Estado da Bahia, Brasil, em gestão plena do sistema. Cad. Saúde Pública. 2010; 26(4): 725-737.

15. Costa GD, Cotta RMM, Franceschini SCC, Batista RS, Gomes AP, Martins PC, Ferreira MLSM. Avaliação em saúde: reflexões inscritas no paradigma sanitário contemporâneo. Physis. 2008; 18(4): 705-726.

16. Castro ME, Moura MAV, Silva LMS. Qualidade da assistência pré-natal: uma perspectiva das puérperas egressas. Rev. RENE. 2010; 11(esp): 72-81.

17. Neto FRGX, Leite JL, Luly PSC, Cunha ICKO, Clemente AS, Dias MAS, Pontes MAC. Qualidade da atenção ao pré-natal na estratégia saúde da família em Sobral, Ceará. Rev. Bras Enferm. 2008; 61(5): 595-602.

18. Domingues RMSM, Hartz ZMA, Leal MC. Avaliação das ações de controle da sífilis e do HIV na assistência pré-natal da rede pública do município do Rio de Janeiro, Brasil. Rev. Bras. Saúde Matern. Infant. 2012; 12(3): 269-280.

19. Quadros LCM, Meincke MK, Lopes CV, Vargas NRC, Schneider CC. Avaliando a realização de exames laboratoriais pelas gestantes durante o pré-natal. Rev. enferm. Saúde. 2011; 1(1): 99-106.

20. Dutra BMA. A questão da fundamentação dos direitos humanos sob o prisma axiológico. Rev Facul Direito UERJ. 2011; 1(18): 1-16.

Received on: 06/05/2014
Required for review: No
Approved on: 06/01/2015
Published on: 01/04/2015

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